State of California, Department of Industrial Relations: Adoption of Regulations

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ADOPT THE FOLLOWING

Title	8	California Code Of Regulations
Division	1:	Department of Industrial Relations
Chapter	1:	Industrial Medical Council
Article	4:	Evaluation Methodology
Section	46:	Method of Evaluation of Neuromusculoskeletal Disability

§ 46. **Method of Evaluation of Neuromusculoskeletal Disability** - The method of measuring the neuromusculoskeletal elements of disability shall be as set forth in the "Guidelines for Evaluation of Neuromusculoskeletal Disability, 2nd Ed." as adopted by the Industrial Medical Council on October 20, 1994, which shall be deemed incorporated by their reference as though fully set forth herein.

NOTE: The "Guidelines for Evaluation of Neuromusculoskeletal Disability, 2nd Ed." do not appear as printed part of these regulations. Copies will be available through the Executive Medical Director of the Industrial Medical Council at P. O. Box 8888, San Francisco, CA 94128-8888.

Authority Cited: Labor Code Section 139.2(j)(2).
Reference: Labor Code Sections 139 and 139.2.

GUIDELINES FOR EVALUATION OF NEUROMUSCULOSKELETAL DISABILITY

I. INTRODUCTION

A. BASIC PURPOSE OF THE GUIDELINES

The purpose of these evaluation guidelines is to develop a more uniform method of evaluating musculoskeletal injuries without diminishing the individual expertise of the participating evaluator. This method will allow involved parties (particularly the WCAB) to review evaluator's reports which employ a more standardized format.

B. GENERAL APPROACH

The evaluator shall personally take the history from the injured worker and perform the examination. The evaluator may have an assistant make an initial outline of the injured worker's history or take excerpts from prior medical records, however the evaluator must review the excerpts and/or outline with the injured worker. Occupational and medical questionnaires may be useful to assist the injured worker in compiling the details of the injury prior to the consultation with the evaluator. Any discrepancies in the various sources of information should be identified and clarified by the evaluator.

The injured worker shall at all times be evaluated in a compassionate and respectful manner.

The evaluator will introduce him/herself, and explain to the injured worker the purpose and scope of the evaluation.

The evaluator must inform the injured worker of any significant medical findings which could impact on his or her health. These findings may not be directly related to the work injury.

II. COMPONENTS OF THE REPORT

A. INITIAL PAGE

Address the report to the referring party(ies) or the DEU office noted on the Request for Summary Rating form. Report on factors influencing the complexity of the examination, being aware that complexity factors may be medical in nature or medical-legal, such as apportionment. Give an explanation if the face to face time of the examination was less than the required twenty minutes.

Give names and professional description of any persons assisting with the report or performing diagnostic or consultative services. Note if there were communication difficulties (e.g. aphasia) or translation services required for the evaluation.

B. HISTORY OF INJURY

Report on the details of the injury, subsequent treatment, injured worker's response to treatment, general description of the injured worker's medical history and any previous injuries or symptoms involving that area of injury.

Note the relevant work history including previous and current jobs. Review and comment on the formal job analysis if it is available.

C. CURRENT SYMPTOMS

Include detailed information concerning abnormal sensations, especially 'pain', since it is the major symptom which results in limitation of activity and associated disability.

Using the patient's own words, describe the pain in terms of: (1) location, (2) frequency, (3) intensity, (4) quality and (5) radiation into the extremities. Report pain radiating into other areas such as the abdomen, groin or genitals, particularly if this results in a separate physical impairment.

When appropriate, mention symptoms such as muscle spasm, cramps, swelling, atrophy, or limping.

State whether or not the injured worker has weakness, stiffness, or numbness.

Do not simply state that the injured worker has "no symptoms". Document the injured worker's responses to your specific questions.

Report on symptoms which may indicate serious, underlying pathology. These findings may require that you make timely referral arrangements for evaluation and treatment by an appropriate specialist.

NOTE: The description of symptoms shall be 'translated' later by the evaluator into ratable language in the "Subjective Factors of Disability" as defined by Packard Thurber.

Describe whether the symptoms are increasing, decreasing or have plateaued. Indicate the period of time over which there has been improvement or deterioration and the injured worker's explanation for any change such as returning to repetitive bending activities.

Give a description of any treatment or self administered procedures (rest, ice, heat, or medication) and any benefit realized.

D. RELATIONSHIP OF IMPAIRMENT TO SYMPTOMS

Assess and report on the effect of the following activities on the injured worker's symptoms:

1. standard work activities;
2. activities specific to the injured worker's job;
3. activities specific to daily living.

Consult Appendix A for a list and description of the various activities to be considered.

Describe the patient's pre-injury capacity, the current functional limitations, and the reason for the limitations for example pain, weakness, or stiffness.

E. PAST MEDICAL HISTORY

Record significant aspects of the injured worker's past medical history, previous injuries, illnesses, and physical conditions or symptoms that are similar or related to the present complaints.

F. PHYSICAL EXAMINATION

See Section 1 for physical examination of specific body parts.

G. REVIEW OF MEDICAL RECORDS

List the medical records which were reviewed with a brief synopsis of relevant information.

H. DIAGNOSTIC TESTING:

List any diagnostic procedures performed, as well as the dates and the results of the procedures. Provide the name, specialty, qualifications and opinion of any consultants.

Order diagnostic studies only when the studies may alter the recommended plan or the evaluator's opinion regarding factors of disability. The evaluator must document the need for these additional studies.

I. DIAGNOSIS

List the relevant diagnosis(es). When appropriate, state if the injury is right or left sided or bilateral. If the diagnosis involves the upper extremity, state whether the dominant or non-dominant limb is involved.

J. OPINIONS & DISCUSSION

State that the report represents your opinions and how those opinions were derived after carefully reviewing the forwarded medical information, the injured worker's subjective statements offered during consultation, and examination findings.

K. CAUSATION

State an opinion as to whether the injury or illness which led to the disability arose out of the employment.

L. PERMANENT and STATIONARY

State whether the injured worker is permanent and stationary and reasons for that opinion. The term permanent and stationary means that the injured worker has reached maximal improvement or his condition has been stationary for a reasonable period of time.

M. TEMPORARY DISABILITY

If the injured worker is not permanent and stationary, describe the work restrictions, any additional treatment and the anticipated length of time necessary to achieve permanent and stationary status.

N. FACTORS OF DISABILITY

Do not provide a "rating" but describe the medical information in such a way as to be used by raters, judges and other concerned parties. The evaluator will describe the subjective and objective components of disability. The following information shall be included:

1. Subjective Factors of Disability

Translate the injured worker's symptoms into ratable language using the terminology found in Appendix A.

2. Objective Factors of Disability

Note those finding which can be measured, observed or demonstrated on testing. They include, but are not limited to: range of motion, strength, sensation, reflexes, anatomical measurements, disfigurement, and radiographic or diagnostic results.

Note if assistive devices, prosthetics, or orthotics are required. Note if the device causes any limitation in motion.

3. Loss of Pre-Injury Capacity

Describe the loss of pre-injury capacity for activities. Report loss of pre-injury capacity for the work activities the injured worker was performing at the time of the injury and for potential activities in the open labor market.

The evaluator will estimate the total or partial loss of the injured worker's pre-injury capacity to lift, bend, stoop, push, pull, climb or other activities involving comparable physical strength. The best means is to describe the injured worker's loss of capacity, such as loss of one-quarter of his ability to lift.

Use of job history and/or description as well as other activities of daily living to estimate the pre-injury capacity, should be noted in the report to substantiate the evaluator's opinion on loss.

4. Work Restrictions

Describe all permanent work restrictions. Be as specific as possible, incorporating the injured worker's history, the RU-90, the DEU Form 100, and a formal job analysis, if it is available.

O. APPORTIONMENT

State if apportionment is indicated and provide reasons for the statement. See the *Physicians Guide Chapter 3* for more information on apportionment.

P. FUTURE MEDICAL CARE

Give reasons for your opinion as to whether further medical treatment is indicated or not. Describe the treatment that you deem necessary including length and frequency.

Q. VOCATIONAL REHABILITATION

If requested, state if the injured employee is a qualified injured worker (QIW).

R. AFFIRMATIONS AND SIGNATURE

The following paragraph must be included and signed and dated by the evaluator. The report must contain an original signature by the evaluator.

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and except as noted herein, that I believe it to be true."

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge.

The foregoing declaration was signed in _____ County, California on _____ (date).

_____
EVALUATOR'S SIGNATURE

SECTION I

LOW BACK INJURIES WITH OR WITHOUT RADIATING SYMPTOMS

I. PHYSICAL EXAMINATION

A. OBSERVATION & INSPECTION

The physical examination shall include relevant description of body habitus such as height and weight and any general observation such as limp or deformities, obvious discomfort when standing or sitting, difficulty in transferring or changing position, or thigh climbing when arising from a seated position. Note any assistive devices, prothestics or orthotics that the injured worker uses and describe those devices. Note any loss of normal contours of the body or abnormal symmetry in the trunk, rib cage, spine or bony prominences such as the posterior superior iliac spine.

Inspect the soft tissues for surgical scars, abrasions, discoloration, birthmarks, swelling or similar abnormalities. Also inspect for obvious atrophy or skeletal deformities such as angulation of healed fractures, varus or valgus joint deformities or amputation.

B. PALPATION

Palpate both bony and soft tissue structures throughout the area of complaint and any other commonly associated areas. The contact should be gentle but firm. As you palpate, gauge skin temperature and take note of any tenderness elicited. Palpate both sides to facilitate bilateral comparison. Any painful areas, fibrosis, swelling, hypertrophy or abnormality should be noted. It is not adequate for the evaluator to state that the palpation was essentially normal without indicating what areas were palpated.

C. RANGE OF MOTION

The evaluator will measure the active range of motion including flexion, extension, lateral bending and rotation of the lumbar spine. Use of goniometers or inclinometers is recommended. The means of measuring the motion shall be reported. For flexion, the distance from the finger tips to the floor will be recorded.

The range of motion will be given in degrees or the percentage of an anticipated normal value. The evaluator should list the range of motion as a ratio of the observed compared to the anticipated normal for that joint.

The reason for any limitation in range of motion, such as pain, tightness or spasm, will be reported. On occasion, gentle passive range of motion may be

performed in addition to active range of motion to determine whether the restriction is due to pain or mechanical block.

D. MEASUREMENTS

Measure the lower extremity leg length, thigh girth and calf girth. The thigh and calf measurements are taken at the same point on each extremity. Measure the thigh at a point 1/3 of the distance from the proximal pole of the patella to the umbilicus. Measure the calf circumference at the largest diameter of the calf muscles. It may be appropriate to take circumferential measurements of other areas if specific atrophy is noted.

Leg length may be measured from the anteriosuperior iliac spine to the medial malleolus, the umbilicus to the medial malleolus or the posterior superior iliac spine to the medial malleolus, when a functional leg length discrepancy is suspected.

E. TESTING

1. ORTHOPEDIC

There are multiple orthopedic tests to aid in the determination of the diagnosis of low back conditions. The appropriate tests will be determined by the evaluator based on the history and other examination findings. The evaluator will use those tests that will assist in ruling-in or ruling-out diagnostic probabilities for that injured worker. Some of the more frequently used tests are: sciatic stretch test such as straight leg raise with and without ankle dorsiflexion, hip function tests such as FABERE (Flexion Abduction External Rotation) and Laguerre as well as other tests such as Trendelenburg, Thompson, Gaenslen, Spurling, and Ely.

If systemic arthritis is a consideration, chest excursion should be reported.

2. NEUROLOGICAL

a. MOTOR EXAMINATION

i. Atrophy of specific muscle groups of the lower extremity should be described. General muscle bulk is assessed by measurements of both calf and thigh, as noted above in D. MEASUREMENTS.

ii. Muscle tone shall be described as increased, normal, decreased or in other appropriate terms.

iii. Muscle strength shall be graded, using a scale such as those provided in Appendix B. If muscle weakness is noted, the evaluator should state

an opinion as to the cause such as neurological deficit, pain, disuse atrophy or lack of effort.

b. SENSORY

The sensory examination shall include response to light touch and pinprick. Response to vibration or two point discrimination may be elicited when indicated.

Pinprick examination of the perianal region and assessment of sphincter tone may be indicated in certain cases.

Any abnormalities shall be described fully and correlated with peripheral nerve or dermatomal patterns. Note if the pattern of sensory impairment is nonphysiological.

c. REFLEXES

The patellar and Achilles deep tendon reflexes shall be obtained and graded as O (absent) to 4 (hyperactive). The normal grade is 2. If a different scale is used, a description of the grading system will be included to indicate normal values. Testing with reinforcement may be indicated. Note if clonus is present. Note whether any other abnormal reflexes were elicited.

d. COORDINATION

Coordination shall be assessed if this is a presenting complaint or if there is a suspicion of spinal or lower extremity motor impairment. In this case, describe the performance of the appropriate tests such as finger to nose or heel to shin.

e. VASCULAR

Bilateral dorsalis pedis and posterior tibial pulses should be evaluated if the history or examination findings indicated vascular etiology. Report varicosities and edema if present or relevant.

f. OTHER

A digital rectal examination may be indicated in certain cases to rule out entities such as tumor.

F. FUNCTIONAL ASSESSMENT

The injured worker should be assessed for tandem (heel-toe) gait, tip-toe gait and heel gait.

The injured worker's ability to sit should be assessed during the consultation and noted in the report.

As indicated, evaluate the injured worker's ability to squat, stand, and perform other ambulatory activities.

APPENDIX A

DESCRIPTION OF ACTIVITIES

BALANCING:	Maintaining body equilibrium
BENDING:	Angulation from neutral position about a joint (e.g. elbow) or spine (e. g. forward)
CARRYING:	Transporting an object, usually holding it in the hands or arms or on the shoulder.
CLIMBING:	Ascending or descending ladders, stairs, scaffolding, ramps, poles, etc. . . . using feet and legs and/or hands and arms.
CRAWLING:	Moving about on hands and knees and feet.
CROUCHING:	Bending body downward and forward by bending lower limbs, pelvis and spine.
FEELING:	Perceiving attributes of objects such as size, shape, temperature, or texture by means of receptors in the skin, particularly those of the finger tips.
FINGERING/ PINCHING:	Picking, pinching or otherwise working with fingers and thumb primarily (rather than with whole hand or arm as in handling).
GRASPING/ HANDLING:	Seizing, holding, grasping, turning or otherwise working with hand or hand (fingering not involved).
JUMPING:	Moving about suddenly by use of leg muscle, leaping from or onto the ground or from one object to another.
KNEELING:	Bending legs at knees to come to rest on knee or knees.
LIFTING:	Raising or lowering an object from one level to another (includes upward pulling)
OVERHEAD/ OVER SHOULDER:	Performing work activities with arm raised and held unsupported, at or above shoulder level.
PIVOTING:	Planting your foot and turning about that point.

PUSHING:	Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).
PULLING:	Exerting force upon an object so that the object moves towards the force (includes jerking).
REACHING:	Extending the hand(s) and arm(s) in any direction.
RUNNING:	Moving in a fast pace, moving the legs rapidly so that for a moment both legs are off the ground.
SITTING:	Remaining in the normal seated position.
SQUATING:	Crouching to sit on your heels, with knees bent and weight on the balls of your feet.
STANDING:	Remaining on one's feet in an upright position at a work station without moving about.
STOOPING:	Bending body downward and forward by bending spine at waist.
TURNING/ TWISTING:	Moving about a central axis, revolve or rotate.
USE OF HAND OR FOOT CONTROLS:	Required to control a machine by use of controls.
WALKING:	Moving about at a moderate pace over even or uneven ground.

APPENDIX B

EXAMPLES OF MUSCLE GRADING CHARTS

Results may be reported using a verbal scale or a percentage loss of muscle strength as follows. In either case, the evaluator must still describe how a given loss of muscle strength affects the injured worker's capacity to perform work.

MUSCLE GRADATION	DESCRIPTION
5-Normal	5-complete range of motion against gravity with full resistance
4-Good	4-complete range of motion against gravity with some resistance
3-Fair	3-complete range of motion against gravity
2-Poor	2-complete range of motion with gravity eliminated
1-Trace	1-reads evidence of slight contractility, no joint motion
0 (Zero)	0-no evidence of contractility

KENDALL	LOVETT	DESCRIPTION
100 % 95 %	Normal Normal -	The ability to hold the test position against gravity and maximum pressure, or the ability to move the part into test position and hold against gravity and maximum pressure.
90 % 80 %	Good + Good	Same as above except holding against moderate pressure.
70 % 60 %	Good - Fair +	Same as above except holding against minimum pressure.
50 %	Fair	The ability to hold the test position against gravity, or the ability to move the part into test position and hold against gravity.
40 %	Fair -	The gradual release from test position against gravity; or the ability to move the part toward test position against gravity almost to completion, or to completion with slight assistance or the ability to complete the arc of motion with gravity lessened.

KENDALL	LOVETT	DESCRIPTION
30 % 20 %	Poor + Poor	The ability to move the part through partial arc of motion with gravity lessened; moderate arc, 30% or poor +; small arc, 20% or poor. To avoid moving a patient into gravity-lessened position, these grades may be estimated on the basis of the amount of assistance given during anti-gravity test movements: A 30% or poor + muscle requires moderate assistance, a 20% or poor muscle requires more assistance.
10 % 5 %	Poor - Trace	In muscles that can be seen or palpated, a feeble contraction may be felt in the muscle, or the tendon may become prominent during the muscle contraction, but there is no visible movement of the part.
0 %	Gone	No contraction felt in the muscle.

KENDALL	LOVETT	DESCRIPTION
30 % 20 %	Poor + Poor	The ability to move the part through partial arc of motion with gravity lessened; moderate arc, 30% or poor +; small arc, 20% or poor. To avoid moving a patient into gravity-lessened position, these grades may be estimated on the basis of the amount of assistance given during anti-gravity test movements: A 30% or poor + muscle requires moderate assistance, a 20% or poor muscle requires more assistance.
10 % 5 %	Poor - Trace	In muscles that can be seen or palpated, a feeble contraction may be felt in the muscle, or the tendon may become prominent during the muscle contraction, but there is no visible movement of the part.
0 %	Gone	No contraction felt in the muscle.

APPENDIX C

DESCRIPTION OF SEVERITY

A *minimal* (mild) pain would constitute an annoyance. but causing no handicap in the performance of the particular activity, would be considered a nonratable permanent disability

A *slight* pain could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.

A *moderate* pain could be tolerated, but would cause marked handicap in the performance of the activity precipitating the pain.

A *severe* pain would preclude the activity precipitating the pain.

The evaluator must demonstrate that he/she understands that the severity levels for pain are descriptions of how the pain affects work performance and ability to work, rather than how severely the injured worker perceives the symptom.

The FREQUENCY of pain and similar symptoms must also be described as:

OCCASIONAL	25% of the time.
INTERMITTENT	50% of the time.
FREQUENT	75% of the time.
CONSTANT	90-100% of the time.

2.5h Changes in Impairment from Prior Ratings

Although a previous evaluator may have considered a medical impairment to be permanent, unanticipated changes may occur: the condition may have become worse as a result of aggravation or clinical progression, or it may have improved. The physician should assess the current state of the impairment according to the criteria in the *Guides*. If an individual received an impairment rating from an earlier edition and needs to be reevaluated because of a change in the medical condition, the individual is evaluated according to the latest information pertaining to the condition in the current edition of the *Guides*.

Valid assessment of a change in the impairment estimate would depend on the reliability of the previous estimate and the evidence upon which it was based. If a prior impairment evaluation was not performed, but sufficient historical information is available to currently estimate the prior impairment, the assessment would be performed based on the most recent *Guides* criteria. However, if the information is insufficient to accurately document the change, then the physician needs to explain that decision and should not estimate a change.

If apportionment is needed, the analysis must consider the nature of the impairment and its relationship to each alleged causative factor, providing an explanation of the medical basis for all conclusions and opinions. (Apportionment and causation are considered more fully in Chapter 1 and are briefly defined in the Glossary.) For example, in apportioning a spine impairment, first the current spine impairment rating is calculated, and then an impairment rating from any preexisting spine problem is calculated. The value for the preexisting impairment rating can be subtracted from the present impairment rating to account for the effects of the intervening injury or disease. Using this approach to apportionment requires accurate information and data to determine both impairment ratings. If different editions of the *Guides* are used, the physician needs to assess their similarity. If the basis of the ratings is similar, a subtraction is appropriate. If they differ markedly, the physician needs to evaluate the circumstances and determine if conversion to the earlier or latest edition of the *Guides* for both ratings is possible. The determination should follow any state guidelines and should consider whichever edition best describes the individual's impairment.

2.6 Preparing Reports

A clear, accurate, and complete report is essential to support a rating of permanent impairment. The following elements in **bold type** should be included in **all** impairment evaluation reports. Other elements listed in *italics* are commonly found within an IME or may be requested for inclusion in an impairment evaluation.

2.6a Clinical Evaluation

2.6a.1 Include a **narrative history** of the medical condition(s) with the onset and course of the condition, symptoms, findings on previous examination(s), treatments, and responses to treatment, including adverse effects. Include information that may be relevant to onset, such as an occupational exposure or injury. Historical information should refer to any relevant investigations. Include a detailed list of prior evaluations in the clinical data section.

2.6a.2 *Include a work history with a detailed, chronological description of work activities, specific type and duration of work performed, materials used in the workplace, any temporal associations with the medical condition and work, frequency, intensity, and duration of exposure and activity, and any protective measures.*

2.6a.3 Assess **current clinical status**, including current symptoms, review of symptoms, physical examination, and a list of contemplated treatment, rehabilitation, and any anticipated reevaluation.

2.6a.4 List **diagnostic study results** and outstanding pertinent **diagnostic studies**. These may include laboratory tests, electrocardiograms, exercise stress studies, radiographic and other imaging studies, rehabilitation evaluations, mental status examinations, and other tests or diagnostic procedures.

2.6a.5 Discuss the medical basis for determining whether the person is at **MMI.** If not, estimate and discuss the expected date of full or partial recovery.

2.6a.6 Discuss **diagnoses, impairments.**

2.6a.7 *Discuss causation and apportionment, if requested, according to recommendations outlined in Chapters 1 and 2.*

2.6a.8 **Discuss impairment rating criteria, prognosis, residual function, and limitations.** Include a discussion of the anticipated clinical course and whether further medical treatment is anticipated. Describe the residual function and the impact of the medical impairment(s) on the ability to perform activities of daily living *and, if requested, complex activities such as work.* List the types of affected activities (see Table 1-2). Identify any medical consequences for performing activities of daily living.

If requested, the physician may need to analyze different job tasks to determine if an individual has the residual function to perform that complex activity. The physician should also identify any medical consequence of performing a complex activity such as work.

2.6a.9 *Explain* any conclusion about the need for restrictions or accommodations for standard activities of daily living or *complex activities such as work.*

2.6b Calculate the Impairment Rating

Compare the medical findings with the impairment criteria listed within the *Guides* and calculate the appropriate impairment rating. Discuss how specific findings relate to and compare with the criteria described in the applicable *Guides* chapter. Refer to and explain the absence of any pertinent data and how the physician determined the impairment rating with limited data.

2.6c. Discuss How the Impairment Rating Was Calculated

2.6c.1 Include an explanation of each impairment value with reference to the applicable criteria of the *Guides*. Combine multiple impairments for a whole person impairment.

2.6c.2 Include a summary list of impairments and impairment ratings by percentage, including calculation of the whole person impairment.

On the following two pages is a standard form that the evaluator may use to ensure that all essential elements are included in the impairment evaluation report. The form may be reproduced without permission from the American Medical Association. Most chapters include a summary form that identifies the salient, specific features to consider for each category of organ system impairment.

Sample Report for Permanent Medical Impairment

Identifiers:

Patient name: _____

Address: _____

Claim #: _____

Date of birth: _____

Date of injury or illness: _____

Examination date: _____

Dates of care by examining physician: _____

Examination location: _____

Examining physician: _____

Introduction: Purpose (impairment or IME evaluation, personal injury, workers' compensation) and procedures (who performed the exam, patient consent, location of examination)

Narrative history: Chief complaints, history of injury or illness, occupational history, past medical history, family history, social history, review of systems

Medical record review: Chronology of medical evaluation, diagnostic studies, and treatment for the injury or illness

Physical examination:

Diagnostic studies:

Diagnoses and Impairments: *(If requested, discuss work relatedness, causation, apportionment, restrictions , accommodations, assistive devices)*

Impairment Rating Criteria: MMI residual function, limitations of activities of daily living, prognosis

Impairment Rating and Rationale Organ system and whole person impairment

Body part or system	Chapter No.	Table No.	% Impairment of the Whole Person
a.			
b.			
c.			
d.			

Calculated total whole person impairment:_____%. Discussion of rationale of impairment rating and any possible inconsistencies in the examination:

Recommendations: Further diagnostic or therapeutic follow-up care

Work ability, work restrictions (If requested, review abilities and limitations in reference to essential job activities):

Division of Workers' Compensation
INDEPENDENT MEDICAL EXAMINER'S NARRATIVE REPORT
CHECKLIST

Purpose: **The IME Program is intended to offer all parties in a workplace injury situation the ability to seek an independent medical opinion about worker injuries. For the process to be useful and fair, those opinions must have some uniformity in scope and depth. Although physician discretion and judgment is always necessary in these cases, consistency of form and process will eliminate unnecessary mistakes or omissions. It should also provide protection for the evaluator in the event of later court review.**

The Examiner's Narrative Report is the ***most important product*** of the Independent Medical Evaluation. It is your only tangible work product from the exam that demonstrates the nature and extent of your review. Your reports are evaluated for completeness, and will be returned to you for further work if they are not adequate. Examiners should, *at minimum,* address the issues listed on the IME Application form for the individual case; however, your evaluation is not necessarily limited to those issues. To ensure a comprehensive review, also address most or all of the following issues, as appropriate to the case.

_____ Identify referral source and type of evaluation
_____ Specify sources of information and medical records reviewed
_____ History - pre-existing status, functional status, occupational status
_____ Physical Exam - detailed structural and regional exam of all involved areas
_____ Behavioral exam
_____ Results and discussion of all pertinent diagnostic testing
_____ Clinical diagnosis
_____ Prognosis - including discussion of Return-to-Work status, with detailed activity restrictions if required
_____ MMI
_____ Permanent partial impairment; include references to AMA Guides tables and figures used
_____ Apportionment (if applicable); if needed, use special apportionment worksheet when apportioning spinal range of motion
_____ Discussion (Your diagnosis, MMI, permanent impairment and any recommendations for continued treatment vs. other physicians' conclusions)
_____ Attach applicable impairment worksheets (spine, upper/lower extremity, etc.)
_____ Summary and conclusions

Remember—the narrative report is due 20 days from the date of the exam.

Thank you!